California Licentiate Supervisor and Operator Permits

(Failure to use your full legal name may result in entrance into the examination being denied.)

Last Name (Please Print)	First Name		Middle Name
Date of Birth	Social Security Number		Phone Number
Mailing Address			E-mail Address
City		State	Zip Code

Pursuant to the authority found in Section 114870 of the California Health and Safety Code and as required by Section 17520 of the California Family Code, providing the social security number is mandatory. The social security number will be used for purposes of identification. The information on this form may be provided to federal, state, or local agencies for law enforcement purposes. This information may also be provided to American Registry of Radiologic Technologists for examination purposes. For information or access to your records, contact the Certification Support Unit at the California Department of Public Health, Radiologic Health Branch (CDPH-RHB), MS 7610, P.O. Box 997414, Sacramento, CA 95899-7414, (916) 327-5106.

Check the appropriate permit category:

- ☐ Fluoroscopy Supervisor and Operator Permit
- ☐ Radiography Supervisor and Operator Permit
- ☐ Dermatology Supervisor and Operator Permit

Return this application with:

- ☐ The non-refundable **application fee** in the form of a check or money order payable to **CDPH-RHB for each permit category:**
  - ☐ **$85.00** for one permit.
  - ☐ **$170.00** for two (Fluoroscopy and Radiography) permits.
- ☐ The non-refundable examination fee(s) of **$250** for one permit examination, or **$500** for two permit examinations, in the form of a cashier's check or money order payable to ARRT, **if the application is postmarked prior to January 1, 2008.** (Personal or business checks are not accepted). **After January 1, 2008, do not send the examination fee to CDPH-RHB. The examination fee will be paid directly to ARRT after you receive a notification letter from CDPH-RHB.**
- ☐ A copy of your certificate in one of the following valid California healing arts licenses: Physician and Surgeon, Osteopathic Physician and Surgeon, Podiatrist, or Chiropractor.

I certify that all information provided with this application is true and correct. I understand that the California Department of Public Health may cancel permits that are procured by fraud, misrepresentation, or mistake, and may revoke permits for the nonpayment of fees. Further, I am aware that it is unlawful to use X-rays on human beings in this state unless I am permitted pursuant to the Radiologic Technology Act and acting within the scope of that permit.

Signature	Date

Mail application, supporting documents, and fee(s) to:

Accounts Receivable and Cashiering Unit
California Department of Public Health
Radiologic Health Branch, MS 7610
P.O. Box 997414
Sacramento, CA 95899-7414

CDPH-RHB Use Only	
Permit Number:	
Class Code:	
Date Issued:	
Issued by:	